STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155121	A. BUILDING _____ B. WING _____	C 11/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT LAFAYETTE	1903 UNION ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for Investigation of Complaints IN00119219, IN00119347 and IN00119453.

Complaint IN00119219 - Substantiated. No deficiencies related to the allegation are cited

Complaint IN00119347 - Substantiated. No deficiencies related to the allegation are cited

Complaint IN00119453 - Substantiated. No deficiencies related to the allegation are cited

Dates of survey:
November 14, 15 and 16, 2012

Facility number: 000051
Provider number: 155121
AIM number: 100275490

Survey team:
Vanda Phelps, RN

Census bed type:
10 SNF
97 SNF/NF
107 Total

Census payor type:
14 Medicare
80 Medicaid
13 Other
107 Total

Sample: 11

Rosewalk Village at Lafayette was found to be in compliance with 42 CFR Part 483, Subpart B and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 410 IAC 16.2 in regard to the Investigation of Complaints IN00119219, IN00119347 and IN00119453. Quality review 11/19/12 by Suzanne Williams, RN	F 000		